Covered Services and Related Limitations

Refer to the Medicaid Guidelines and Performance Measurements for Child Care Coordination (Appendix 7 of this handbook) for detailed information about the benefit's operational standards and performance measurements.

This chapter outlines the Medicaid-approved services, conditions, and limitations for child care coordination (CCC) services. Child care coordination services include all of the following:

- Initial assessment.
- Care plan development.
- Ongoing care coordination and monitoring.

Wisconsin Medicaid does *not* cover direct service provision as part of the CCC benefit.

Note: Providers should be prepared to offer all three components of the CCC benefit, not just the initial assessment, to eligible recipients.

Refer to the Medicaid Guidelines and Performance Measurements for Child Care Coordination (Appendix 7 of this handbook) for detailed information about the benefit's operational standards and performance measurements. Providers are encouraged to use the guidelines to help ensure that quality services are provided and activities are directed toward the program's objectives and goals as stated in the General Information chapter of this handbook.

Wisconsin Medicaid also uses the guidelines to monitor the administration of the benefit.

Initial Assessment

Providers are required to administer an initial, comprehensive risk assessment to all recipients, including recipients who received PNCC services. The purpose of this assessment is to determine the needs and strengths of the recipients. The Department of Health and Family Services' (DHFS)-approved tool is the Family Questionnaire (Appendix 8 of this handbook).

Complete *every* section on the Family Questionnaire unless the recipient objects to a particular section.

The Family Questionnaire must be:

- Reviewed and finalized in a face-to-face contact with the recipient.
- Signed and dated by the agency staff member who completed the questionnaire.

The person administering the Family Questionnaire must be an employee of the Medicaid-certified care coordination agency or an employee of an agency under contract to the care coordination agency.

Qualified professionals are required to review and initial all Family Questionnaires completed by paraprofessional staff.

According to HFS 105.52, Wis. Admin. Code, types of qualified professionals include:

- A nurse practitioner licensed as a certified nurse pursuant to s. 441.06, Wis. Stats., and currently certified by the American Nurses' Association, the National Board of Pediatric Nurse Practitioners and Associates or the Nurses' Association of the American College of Obstetricians and Gynecologists' Certification Corporation.
- A nurse midwife certified under HFS 105.201, Wis. Admin. Code.
- A public health nurse meeting the qualifications of HFS 139.08, Wis. Admin. Code.
- A physician licensed under ch. 448, Wis. Stats., to practice medicine or osteopathy.
- A physician assistant certified under ch. 448, Wis. Stats.
- A dietitian certified or eligible for registration by the Commission on Dietetic Registration of the American Dietetic

Association with at least two years of community health experience. (Per proposed rule change, the following is also acceptable: A dietician certified by the State of Wisconsin [CD] or registered by the American Dietetic Association [RD] with at least two years of community health experience.)

- A certified nurse with at least two years of experience in maternity nursing and/or community health service.
- A social worker with at least a bachelor's degree and two years of experience in a health care or family services program.
- A health educator with a master's degree in health education and at least two years of experience in community health services.

Wisconsin Medicaid reimburses for the administration of the Family Questionnaire regardless of the recipient's score. Recipients may be reassessed at any time, but providers need only readminister the entire Family Questionnaire if the recipient's situation changes significantly.

Wisconsin Medicaid will reimburse only one comprehensive assessment per 365 days.

Providers may obtain copies of the Family Questionnaire at no cost by writing to:

Division of Health Care Financing
Bureau of Fee-for-Service Health Care Benefits
Attn: Forms Manager
P.O. Box 309
Madison, WI 53701-0309

When requesting the Family Questionnaire, note the form number DOH 1118 on the request.

Care Plan Development

Wisconsin Medicaid will reimburse care planning as a CCC service when provided by qualified staff. Care planning includes developing *and* implementing the care plan.

Wisconsin Medicaid will reimburse the development of a care plan for recipients who score 70 or more points on the Family Questionnaire. A completed questionnaire must predate the care plan.

Medicaid reimburses for the development of one care plan per recipient, per 365 days. (Wisconsin Medicaid reimburses for updates to the care plan under the ongoing care coordination and monitoring procedure code.)

The care coordinator is required to develop an individualized care plan for each eligible recipient. Medicaid does not require a specific care plan format, but the care plan must be:

- Developed (or reviewed) and signed or initialed by a qualified professional.
- In writing.
- Based on the results of the Family Questionnaire.

Note: Providers should note in the care plan if the recipient does not want to address issues identified in the Family Questionnaire.

Refer to Appendix 11 of this handbook for a blank model of a care plan. Providers are not required to use the sample.

To ensure the recipient's needs are met, the care plan must:

- Identify needs, problems, necessary services, necessary referrals, and frequency of monitoring.
- Include an array of services regardless of funding sources.

To the maximum extent possible, include the recipient in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The recipient and care coordinator who developed the care plan are required to sign and date the plan.

The care coordinator is required to develop an individualized care plan for each eligible recipient.

Ongoing Care Coordination and Monitoring

A collateral is anyone who has direct supportive contact with the recipient, such as a family member, friend, service provider, guardian, housemate, or school official.

Ongoing care coordination and monitoring activities must be based on the recipient's written care plan. Wisconsin Medicaid will not cover ongoing care coordination and monitoring services that are not based on the recipient's care plan.

Ongoing care coordination and monitoring is a covered CCC service for recipients who score 70 or more points on the Family Questionnaire. Except for urgent care situations, providers are required to complete the Family Questionnaire and a care plan for each recipient prior to providing ongoing care coordination and monitoring services. Providers may offer ongoing care coordination services on the same date they completed the Family Questionnaire and care plan.

Activities for Ongoing Care Coordination and Monitoring

Covered activities include the following:

- Recipient contacts.
- Collateral contacts.
- Information and referral.
- Assessment and care plan updates.
- Recordkeeping.

Recipient Contacts

Recipient contacts may be face-to-face, by telephone, or in writing, as appropriate. Wisconsin Medicaid does not cover recipient contacts for the direct provision of services. Wisconsin Medicaid reimburses for the provision of many medical services under other Medicaid benefits.

Wisconsin Medicaid does not limit the number of contacts providers may have with a recipient.

Family Members
Wisconsin Medicaid covers care coordination services provided to Medicaid-eligible family members. Services to non-Medicaid-eligible family members (including mothers who become ineligible for Medicaid) are covered only as outlined below. The need for care coordination services provided to family members must be identified in the recipient's care plan and must be directly related to meeting the goals and objectives of the benefit.

Family Members Not Eligible for Medicaid
Providers may assist a non-Medicaid-eligible family member in locating and accessing services only if the service is directly related to addressing the needs of the eligible recipient.

For example, the provider is providing services to a family of four. The mother, the baby and the grandmother are all eligible for Medicaid. The baby's father is not. The baby has special health care needs. Wisconsin Medicaid will cover care coordination services related to assisting the father in locating and accessing educational resources necessary to help him better meet the baby's needs. However, Medicaid would not cover care coordination activities related to assisting the father in accessing needed substance abuse treatment services for himself.

Collateral Contacts

A collateral is anyone who has direct supportive contact with the recipient, such as a family member, friend, service provider, guardian, housemate, or school official. Since the purpose of contacts with a collateral is to mobilize services and support on behalf of the recipient, the provider is required to identify the role of the collateral in the recipient's care plan.

Collateral contacts also include time spent on client-specific meetings and formal case consultations with other professionals or supervisors. Do not include time spent discussing or meeting on non-client-specific or general program issues.

Wisconsin Medicaid will reimburse collateral contacts even if there is no recipient contact during the month for which the provider is billing.

Information and Referral

Information and referral means providing recipients with current information about available resources and programs to help recipients gain access to needed services. Providers are required to ensure follow up on all referrals within two weeks, unless otherwise stated. Wisconsin Medicaid reimburses information and referral under ongoing care coordination and monitoring.

Please refer to Appendix 9 of this handbook for a model of a Referral Form.

Refer to Appendix 13 of this handbook for general information on HealthCheck screens and Appendix 14 for the HealthCheck screening schedule.

Appendix 15 of this handbook includes a list of resources that providers and recipients may consult.

Assessment and Care Plan Updates

Providers may update the Pregnancy Questionnaire and care plan, and administer other assessment tools, when necessary. Wisconsin Medicaid reimburses these activities as ongoing care coordination and monitoring services.

Assessment Updates
Providers may update the Family Questionnaire as frequently as needed. Providers may also administer other assessment instruments periodically, if appropriate, to determine the child's (or mother's) progress toward meeting basic developmental milestones or program goals. For example, the assessment tools may include Denver Developmental, Wisconsin Child Protective Services Risk Management System, or the HOME Screening tool.

Use the ongoing care coordination and monitoring procedure code (W7097) when billing for updates to the Family Questionnaire and/or administration of other assessments.

Care Plan Updates
Providers are required to review and update the care plan at least every 60 days, or earlier if the recipient's needs change, during the first year of the child's life. Thereafter, providers should review and update the care plan at least every 180 days. If necessary, providers should update the recipient's care plan during each visit.

The provider and the recipient are required to sign and date all updates to the care plan. The provider may initial updates to the care plan if a signature page is included in the recipient's file. Providers are required to keep signed copies of the updates in the recipient's file.

Use the ongoing care coordination and monitoring procedure code (W7097) when billing for updates to the care plan.

Providers are required to review and update the care plan at least every 60 days, or earlier if the recipient's needs change, during the first year of the child's life.

Recordkeeping

Wisconsin Medicaid considers recordkeeping a reimbursable ongoing care coordination and monitoring activity. Reimbursable recordkeeping activities include time spent on the following:

- Updating care plans.
- Documenting recipient and collateral contacts.
- Preparing and responding to correspondence to and for recipients and collaterals.
- Documenting the recipient's activities in relation to the care plan.

Wisconsin Medicaid reimburses for recordkeeping only if a recipient or collateral contact occurred during the month for which the provider is billing.

If a recipient or collateral contact occurs on the last day of the month, the provider may bill Medicaid for the documentation of the contact in the following month (e.g., if the contact occurred on June 30, the provider may bill for the contact with the July contacts). Wisconsin Medicaid will only allow this exception if the provider documents the contact no later than the next business day.

Provision of Services in Urgent Situations

When ongoing care coordination services are provided in an urgent situation (e.g., the family is homeless or lacks food), the provider is required to:

- Document the nature of the urgent situation.
- Complete the Family Questionnaire and care plan as soon as possible but no later than 30 days following the actions taken to alleviate the urgent situation.

Note: Providers may offer ongoing care coordination services to recipients in urgent situations, but Wisconsin Medicaid will not reimburse for these services when they are provided to recipients who score fewer than 70 points on the Family Questionnaire.

As part of the care planning process, the care coordinator is required to discuss and document the frequency of ongoing contacts and monitoring with the recipient (and the recipient's collaterals, if appropriate).

Frequency of Ongoing Monitoring

As part of the care planning process, the provider is required to discuss and document the frequency of ongoing contacts and monitoring with the recipient (and the recipient's collaterals, if appropriate). The care coordinator is required to note the rationale for contacts that are less frequent than the following:

- A contact (face-to-face or telephone) with the recipient every 30 days, if the recipient has a child aged 6 months or less.
- A face-to-face contact with the recipient every 60 days, if the recipient has a child aged 12 months or less.
- A face-to-face or telephone contact with the recipient every 90 days after the first year of the child's life.

When the recipient is a child under age 18 who is living with the parent(s) or guardian, the provider satisfies the recipient contact requirements if the face-to-face contact is with either the recipient or with the custodial parent(s) or guardian.

Recipient Records

According to HFS 106.02(9), Wis. Admin. Code, all providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and records. Providers may keep records in written or electronic formats. If providers keep electronic records, they are required to have hard copies available for review and audit.

As defined in HFS 105.52(5), Wis. Admin. Code, the recipient's file must include the following documents, as appropriate:

- The recipient's completed Family Questionnaire. The Family Questionnaire must be scored, signed, and dated.
- The recipient's care plan, signed and dated as required. The provider may initial the care plan if a signature page is included in the recipient's record.
- A log that clearly and concisely documents all care coordination activities. All entries must be signed and dated.
- Completed consent document(s) for release of information.
- A written record of all recipient-specific care coordination and monitoring activities. The record must include documentation of the following information:
  1. The recipient's name.
  2. The date of the contact.
  3. The full name and title of the person who made the contact.
  4. A clear description of the reason and nature of the contact.
  5. The results of the contact.
  6. The length of time of the contact (the number of minutes or the exact time; for example, 9:15-10:05 a.m.).
  7. Where or how the contact was made.
- Referrals and follow up.
- All pertinent correspondence relating to coordination of the recipient's care.

The following are general guidelines for documentation of activities:

- Maintain accurate and legible documentation.

- Correct errors with caution. Do not erase or obliterate errors in established records. Instead, draw a line through the error so the words remain legible. Sign or initial and date the correction.
- Arrange the file in logical order if possible, so that documents can easily be reviewed and audited.
- Ensure that all entries are signed and dated and in chronological order. Initials are acceptable if the recipient's file includes a page bearing the provider's full name and signature.
- Keep documentation concise, but descriptive and pertinent. The notation for each entry should be reasonably reflective of the length of time documented for the activity.
  For example, an entry stating, "Called Recipient X to remind her of baby's HealthCheck appointment" should not have a length of time of one hour.
  A more reasonable notation would state: "Called Recipient X to remind her of baby's upcoming HealthCheck appointment. Made sure that she knew the name and location of the clinic and knew the name of the pediatrician. Answered Recipient X's questions regarding the appointment, transportation arrangement, and child care for her other children. Provided her with the name and telephone numbers of several transportation and day care providers in the area. Made plans with the recipient for a follow-up home visit."
- If unusual abbreviations and symbols are used routinely (e.g., abbreviations pertaining to internal policy or personal shorthand codes), maintain a key describing each one.

Please refer to Appendix 12 of this handbook for a completed sample time log form.

Safeguarding Recipient Information

State and federal laws require that the personal information of all Medicaid recipients be safeguarded. However, when providing care coordination services, providers may need to obtain or release recipient information on behalf of the recipient. To comply with state and federal laws, providers may release recipient-specific information if:

- The recipient has granted written authorization to the provider.
- The recipient has signed and dated the authorization.

In cases where more stringent laws govern the release of certain personal information, providers are required to comply with those laws. It is the provider's responsibility to be aware of patient confidentiality laws.

For a model of a release of information form, please consult the Informed Consent to Release/Obtain Health Care Information form in Appendix 10 of this handbook.

Please refer to HFS 104.01(3), Wis. Admin. Code, and to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional information on maintenance and confidentiality of Medicaid recipient records.

A recipient should not require child care coordination services from more than one provider.

Duplication of Services

Child Care Coordinators

A recipient should not require CCC services from more than one provider. Although Medicaid does not deny claims for concurrent services, both providers are notified of the overlap. It is the providers' responsibility to eliminate the overlap by communicating with the family and with each other to determine which provider will continue to provide CCC services.

Other Care Coordinators

When multiple family members have care coordinators (case managers), the care plan must identify the role of each care coordinator. Coordinators may not duplicate services. This requirement applies whether or not Medicaid

covers the other care coordinator's services. The need for more than one service coordinator in the family must be reassessed after 12 months. The family's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap.

If a family is involved in the child welfare system, the child care coordination provider may not bill Wisconsin Medicaid for ongoing care coordination services.

Coordinating Prenatal Care Coordination Services and Child Care Coordination Services

The Wisconsin Medicaid PNCC benefit covers the period of pregnancy through the 60th day (the postpartum period) following delivery. During the postpartum period, CCC providers may be reimbursed through the CCC benefit for administering the Family Questionnaire and developing a care plan. However, providers may not bill Wisconsin Medicaid for ongoing CCC services (W7097) provided to recipients receiving PNCC services, except as outlined here.

Wisconsin Medicaid covers ongoing CCC services provided to a recipient receiving PNCC services if the following information is documented in the recipient's record:

- The recipient's care plan specifically addresses the need for both services at the same time, as demonstrated in the following two examples:
  Example 1: A recipient receiving PNCC services has just given birth to healthy twins. However, the recipient is a 19-year-old, first-time mother who moves frequently and is sometimes homeless. At present, she lives with an abusive partner who is often absent for days at a time. She receives little or no emotional support from family members and is not sure she is happy with twins.
  In this example, the prenatal care coordinator may decide (with the recipient) to include the child care coordinator during the postpartum period because of the recipient's immediate and significant needs.
  Example 2: A recipient receiving CCC services becomes pregnant. The recipient has a child who is at high risk for child abuse and/or neglect, has a history of gestational diabetes, poor nutrition, and other significant medical problems. The recipient also has a history of poor compliance with prenatal medical appointments and advice.
  In this situation, the child care coordinator may decide (in consultation with the recipient) that the expertise of a prenatal care coordinator is also appropriate.
- The recipient's care plan includes a clear delineation of the role of each care coordinator (regardless of whether the care coordinators are employed by the same or different agencies). The care coordinators should decide, along with the recipient, which care coordinator will provide or follow up on which services.
- The services provided by the care coordinators are not duplicative.
- The recipient's care plan addresses the frequency of contacts between the care coordinators. The care coordinators must have a face-to-face or telephone contact to discuss the recipient's progress every 60 days, at a minimum. The need for ongoing joint care coordination should be reassessed during that time.

Child Care Coordination and Child Welfare

Wisconsin Medicaid covers CCC services provided to families who are undergoing a child protective services investigation or initial assessment. These families are not yet receiving ongoing child welfare case management services.

If a family is involved in the child welfare system, the CCC provider may not bill Wisconsin Medicaid for ongoing care coordination services. However, Wisconsin Medicaid will cover two concurrent visits

between the CCC provider and the Safety Services or ongoing case management provider if the family is receiving either:

- Services from a Safety Services provider under contract with the Bureau of Milwaukee Child Welfare.
- Ongoing case management services through the child welfare system.

Providers are required to consult with the family and the Safety Services or ongoing case management provider regarding the necessity and timing of concurrent visits. Providers are required to document the reason for the joint visits.

Providers are encouraged to develop referral protocols and maintain working relationships with the Safety Services and child protective services providers in their service areas.

Referrals From the Child Welfare System

In some cases, families will be identified by the child welfare system, including Safety Services, prior to receiving CCC services. The CCC provider may accept these referrals in the following situations:

- The family meets the eligibility criteria for the benefit.
- The family became involved with the child welfare system, including Safety Services, within eight weeks following the birth of the baby, regardless of the age of the child at the time of the referral.

Reduction or Termination of Ongoing Care Coordination Services

If a provider needs to reduce or terminate ongoing care coordination services for any reason, the provider should notify the recipient in advance and document this in the recipient's record. A decision that services can be reduced or terminated should be mutually agreed upon by the provider and recipient. The recipient's file must include a statement, signed and dated by the recipient, indicating agreement with the decision to terminate services. Changes in the care plan should always be discussed with the recipient/ guardian/parent.

In circumstances when the provider is unable to obtain a signature from the recipient for the termination of services (for example, the recipient consistently misses meetings with the provider and does not follow through on referrals, but indicates she wants to continue receiving CCC services), the recipient's file must include documentation of all attempts to contact the recipient through telephone logs and returned or certified mail. The provider is encouraged to provide the recipient with the names and addresses of other CCC providers.

If a provider terminates ongoing CCC services for any reason, the recipient's case is closed. However, there is no limit to the number of times a provider may reopen a recipient's case. The provider is required to document in the recipient's record why the case has been closed and reopened.

There is no limit to the number of times a provider may reopen a recipient's case.

Other Limitations

The following related limitations apply to CCC services in addition to the other limitations stated in this handbook:

1. Child care coordination services are available to recipients who are inpatients in hospital or nursing facilities if:

   - The services do not duplicate discharge planning services that the hospital or nursing facility is required to provide.
   - The service is provided during the 30 days prior to discharge.

2. Wisconsin Medicaid will only reimburse ongoing care coordination and monitoring services *once* per recipient per month of service. The units billed are the sum of the time for the month.

Noncovered Services

The following services are not covered under the Medicaid CCC benefit:

1. The provision of diagnostic, treatment, or other direct services. Direct services include, but are not limited to, diagnosis of a physical or mental illness and administration of medications.
2. Recipient vocational training.
3. Legal advocacy by an attorney or paralegal.
4. Ongoing care coordination and monitoring services which are not based on the recipient's current care plan.
5. Ongoing care coordination and monitoring services which are not necessary to meet the CCC benefit goals.
6. Transportation (provider or recipient mileage or travel time).
7. Interpreter services.
8. Missed appointments (no shows).